



General Assembly

Substitute Bill No. 6367

January Session, 2013



**AN ACT IMPLEMENTING THE GOVERNOR'S BUDGET
RECOMMENDATIONS FOR HUMAN SERVICES PROGRAMS.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Subsection (b) of section 10-295 of the general statutes is
2 repealed and the following is substituted in lieu thereof (*Effective July*
3 *1, 2013*):

4 (b) The Commissioner of Rehabilitation Services shall expend funds
5 for the services made available pursuant to subsection (a) of this
6 section from the educational aid for blind and visually handicapped
7 children account in accordance with the provisions of this subsection.
8 The expense of such services shall be paid by the state in an amount
9 not to exceed six thousand four hundred dollars in any one fiscal year
10 for each child who is blind or visually impaired. The Commissioner of
11 Rehabilitation Services may adopt, in accordance with the provisions
12 of chapter 54, such regulations as the commissioner deems necessary
13 to carry out the purpose and intent of this subsection.

14 (1) The Commissioner of Rehabilitation Services shall provide, upon
15 written request from any interested school district, the services of
16 teachers of the visually impaired, based on the levels established in the
17 individualized education or service plan. The Commissioner of
18 Rehabilitation Services shall also make available resources, including,

19 but not limited to, the Braille and large print library, to all teachers of
20 public and nonpublic school children. The commissioner may also
21 provide vision-related professional development and training to all
22 school districts and cover the actual cost for paraprofessionals from
23 school districts to participate in agency-sponsored Braille training
24 programs. The commissioner shall utilize education consultant
25 positions, funded by moneys appropriated from the General Fund, to
26 supplement new staffing that will be made available through the
27 educational aid for the blind and visually handicapped children
28 account, which shall be governed by formal written policies
29 established by the commissioner.

30 (2) The Commissioner of Rehabilitation Services shall use funds
31 appropriated to said account, first to provide specialized books,
32 materials, equipment, supplies, adaptive technology services and
33 devices, specialist examinations and aids, preschool programs and
34 vision-related independent living services, excluding primary
35 educational placement, for eligible children without regard to a per
36 child statutory maximum.

37 (3) The Commissioner of Rehabilitation Services may, within
38 available appropriations, employ certified teachers of the visually
39 impaired in sufficient numbers to meet the requests for services
40 received from school districts. In responding to such requests, the
41 commissioner shall utilize a formula for determining the number of
42 teachers needed to serve the school districts, crediting six points for
43 each Braille-learning child and one point for each other child, with one
44 full-time certified teacher of the visually impaired assigned for every
45 twenty-five points credited. The commissioner shall exercise due
46 diligence to employ the needed number of certified teachers of the
47 visually impaired, but shall not be liable for lack of resources. Funds
48 appropriated to said account may also be utilized to employ
49 rehabilitation teachers, rehabilitation technologists and orientation and
50 mobility teachers in numbers sufficient to provide compensatory skills
51 evaluations and training to blind and visually impaired children. In

52 addition, up to five per cent of such appropriation may also be utilized
53 to employ special assistants to the blind and other support staff
54 necessary to ensure the efficient operation of service delivery. Not later
55 than October first of each year, the Commissioner of Rehabilitation
56 Services shall determine the number of teachers needed based on the
57 formula provided in this subdivision. Based on such determination,
58 the Commissioner of Rehabilitation Services shall estimate the funding
59 needed to pay such teachers' salaries, benefits and related expenses.

60 (4) In any fiscal year, when funds appropriated to cover the
61 combined costs associated with providing the services set forth in
62 subdivisions (2) and (3) of this subsection are projected to be
63 insufficient, the Commissioner of Rehabilitation Services [shall be
64 authorized to] may collect revenue from all school districts that have
65 requested such services on a per student pro rata basis, in the sums
66 necessary to cover the projected portion of these services for which
67 there are insufficient appropriations.

68 [(5) Remaining funds in said account, not expended to fund the
69 services set forth in subdivisions (2) and (3) of this subsection, shall be
70 used to cover on a pro rata basis, the actual cost with benefits of
71 retaining a teacher of the visually impaired, directly hired or
72 contracted by the school districts which opt to not seek such services
73 from the Commissioner of Rehabilitation Services, provided such
74 teacher has participated in not less than five hours of professional
75 development training on vision impairment or blindness during the
76 school year. Reimbursement shall occur at the completion of the school
77 year, using the caseload formula denoted in subdivision (3) of this
78 section, with twenty-five points allowed for the maximum
79 reimbursable amount as established by the commissioner annually.

80 (6) Remaining funds in such account, not expended to fund the
81 services set forth in subdivisions (2), (3) and (5) of this subsection, shall
82 be distributed to the school districts on a pro rata formula basis with a
83 two-to-one credit ratio for Braille-learning students to non-Braille-
84 learning students in the school district based upon the annual child

85 count data provided pursuant to subdivision (1) of this subsection,
86 provided the school district submits an annual progress report in a
87 format prescribed by the commissioner for each eligible child.]

88 Sec. 2. Section 17b-607 of the general statutes is repealed and the
89 following is substituted in lieu thereof (*Effective July 1, 2013*):

90 (a) The Commissioner of [Social] Rehabilitation Services is
91 authorized to establish and administer a fund to be known as the
92 Assistive Technology Revolving Fund. Said fund shall be used by said
93 commissioner to make loans to persons with disabilities, senior
94 citizens or the family members of persons with disabilities and senior
95 citizens for the purchase of assistive technology and adaptive
96 equipment and services. Each such loan shall be made for a term of not
97 more than [five] ten years. Any loans made under this section shall
98 bear interest at a [rate to be determined in accordance with subsection
99 (t) of section 3-20] fixed rate determined by the commissioner, not to
100 exceed six per cent. Said commissioner is authorized to expend any
101 funds necessary for the reasonable direct expenses relating to the
102 administration of said fund. Said commissioner shall adopt
103 regulations, in accordance with the provisions of chapter 54, to
104 implement the purposes of this section.

105 (b) The State Bond Commission shall have power from time to time
106 to authorize the issuance of bonds of the state in one or more series in
107 accordance with section 3-20 and in a principal amount necessary to
108 carry out the purposes of this section, but not in excess of an aggregate
109 amount of one million dollars. All of said bonds shall be payable at
110 such place or places as may be determined by the Treasurer pursuant
111 to section 3-19 and shall bear such date or dates, mature at such time or
112 times, not exceeding five years from their respective dates, bear
113 interest at such rate or different or varying rates and payable at such
114 time or times, be in such denominations, be in such form with or
115 without interest coupons attached, carry such registration and transfer
116 privileges, be payable in such medium of payment and be subject to
117 such terms of redemption with or without premium as, irrespective of

118 the provisions of said section 3-20, may be provided by the
119 authorization of the State Bond Commission or fixed in accordance
120 therewith. The proceeds of the sale of such bonds shall be deposited in
121 the Assistive Technology Revolving Fund created by this section. Such
122 bonds shall be general obligations of the state and the full faith and
123 credit of the state of Connecticut are pledged for the payment of the
124 principal of and interest on such bonds as the same become due.
125 Accordingly, and as part of the contract of the state with the holders of
126 such bonds, appropriation of all amounts necessary for punctual
127 payment of such principal and interest is hereby made and the
128 Treasurer shall pay such principal and interest as the same become
129 due. Net earnings on investments or reinvestments of proceeds,
130 accrued interest and premiums on the issuance of such bonds, after
131 payment therefrom of expenses incurred by the Treasurer or State
132 Bond Commission in connection with their issuance, shall be deposited
133 in the General Fund of the state.

134 (c) There is established, within the Department of Rehabilitation
135 Services, the Connecticut Tech Act Project. In accordance with the
136 provisions of 29 USC 3001, the project may provide assistive
137 technology evaluation and training services upon the request of any
138 person or any public or private entity, to the extent persons who
139 provide assistive technology services are available. The project may
140 charge a fee to any person or entity receiving such assistive technology
141 evaluation and training services to reimburse the department for its
142 costs. The Commissioner of Rehabilitation Services shall establish fees
143 at reasonable rates that will cover the department's direct and indirect
144 costs.

145 Sec. 3. Subdivision (4) of subsection (f) of section 17b-340 of the
146 general statutes is repealed and the following is substituted in lieu
147 thereof (*Effective July 1, 2013*):

148 (4) For the fiscal year ending June 30, 1992, (A) no facility shall
149 receive a rate that is less than the rate it received for the rate year
150 ending June 30, 1991; (B) no facility whose rate, if determined pursuant

151 to this subsection, would exceed one hundred twenty per cent of the
152 state-wide median rate, as determined pursuant to this subsection,
153 shall receive a rate which is five and one-half per cent more than the
154 rate it received for the rate year ending June 30, 1991; and (C) no
155 facility whose rate, if determined pursuant to this subsection, would be
156 less than one hundred twenty per cent of the state-wide median rate,
157 as determined pursuant to this subsection, shall receive a rate which is
158 six and one-half per cent more than the rate it received for the rate year
159 ending June 30, 1991. For the fiscal year ending June 30, 1993, no
160 facility shall receive a rate that is less than the rate it received for the
161 rate year ending June 30, 1992, or six per cent more than the rate it
162 received for the rate year ending June 30, 1992. For the fiscal year
163 ending June 30, 1994, no facility shall receive a rate that is less than the
164 rate it received for the rate year ending June 30, 1993, or six per cent
165 more than the rate it received for the rate year ending June 30, 1993.
166 For the fiscal year ending June 30, 1995, no facility shall receive a rate
167 that is more than five per cent less than the rate it received for the rate
168 year ending June 30, 1994, or six per cent more than the rate it received
169 for the rate year ending June 30, 1994. For the fiscal years ending June
170 30, 1996, and June 30, 1997, no facility shall receive a rate that is more
171 than three per cent more than the rate it received for the prior rate
172 year. For the fiscal year ending June 30, 1998, a facility shall receive a
173 rate increase that is not more than two per cent more than the rate that
174 the facility received in the prior year. For the fiscal year ending June
175 30, 1999, a facility shall receive a rate increase that is not more than
176 three per cent more than the rate that the facility received in the prior
177 year and that is not less than one per cent more than the rate that the
178 facility received in the prior year, exclusive of rate increases associated
179 with a wage, benefit and staffing enhancement rate adjustment added
180 for the period from April 1, 1999, to June 30, 1999, inclusive. For the
181 fiscal year ending June 30, 2000, each facility, except a facility with an
182 interim rate or replaced interim rate for the fiscal year ending June 30,
183 1999, and a facility having a certificate of need or other agreement
184 specifying rate adjustments for the fiscal year ending June 30, 2000,
185 shall receive a rate increase equal to one per cent applied to the rate the

186 facility received for the fiscal year ending June 30, 1999, exclusive of
187 the facility's wage, benefit and staffing enhancement rate adjustment.
188 For the fiscal year ending June 30, 2000, no facility with an interim rate,
189 replaced interim rate or scheduled rate adjustment specified in a
190 certificate of need or other agreement for the fiscal year ending June
191 30, 2000, shall receive a rate increase that is more than one per cent
192 more than the rate the facility received in the fiscal year ending June
193 30, 1999. For the fiscal year ending June 30, 2001, each facility, except a
194 facility with an interim rate or replaced interim rate for the fiscal year
195 ending June 30, 2000, and a facility having a certificate of need or other
196 agreement specifying rate adjustments for the fiscal year ending June
197 30, 2001, shall receive a rate increase equal to two per cent applied to
198 the rate the facility received for the fiscal year ending June 30, 2000,
199 subject to verification of wage enhancement adjustments pursuant to
200 subdivision (14) of this subsection. For the fiscal year ending June 30,
201 2001, no facility with an interim rate, replaced interim rate or
202 scheduled rate adjustment specified in a certificate of need or other
203 agreement for the fiscal year ending June 30, 2001, shall receive a rate
204 increase that is more than two per cent more than the rate the facility
205 received for the fiscal year ending June 30, 2000. For the fiscal year
206 ending June 30, 2002, each facility shall receive a rate that is two and
207 one-half per cent more than the rate the facility received in the prior
208 fiscal year. For the fiscal year ending June 30, 2003, each facility shall
209 receive a rate that is two per cent more than the rate the facility
210 received in the prior fiscal year, except that such increase shall be
211 effective January 1, 2003, and such facility rate in effect for the fiscal
212 year ending June 30, 2002, shall be paid for services provided until
213 December 31, 2002, except any facility that would have been issued a
214 lower rate effective July 1, 2002, than for the fiscal year ending June 30,
215 2002, due to interim rate status or agreement with the department shall
216 be issued such lower rate effective July 1, 2002, and have such rate
217 increased two per cent effective June 1, 2003. For the fiscal year ending
218 June 30, 2004, rates in effect for the period ending June 30, 2003, shall
219 remain in effect, except any facility that would have been issued a
220 lower rate effective July 1, 2003, than for the fiscal year ending June 30,

221 2003, due to interim rate status or agreement with the department shall
222 be issued such lower rate effective July 1, 2003. For the fiscal year
223 ending June 30, 2005, rates in effect for the period ending June 30, 2004,
224 shall remain in effect until December 31, 2004, except any facility that
225 would have been issued a lower rate effective July 1, 2004, than for the
226 fiscal year ending June 30, 2004, due to interim rate status or
227 agreement with the department shall be issued such lower rate
228 effective July 1, 2004. Effective January 1, 2005, each facility shall
229 receive a rate that is one per cent greater than the rate in effect
230 December 31, 2004. Effective upon receipt of all the necessary federal
231 approvals to secure federal financial participation matching funds
232 associated with the rate increase provided in this subdivision, but in
233 no event earlier than July 1, 2005, and provided the user fee imposed
234 under section 17b-320 is required to be collected, for the fiscal year
235 ending June 30, 2006, the department shall compute the rate for each
236 facility based upon its 2003 cost report filing or a subsequent cost year
237 filing for facilities having an interim rate for the period ending June 30,
238 2005, as provided under section 17-311-55 of the regulations of
239 Connecticut state agencies. For each facility not having an interim rate
240 for the period ending June 30, 2005, the rate for the period ending June
241 30, 2006, shall be determined beginning with the higher of the
242 computed rate based upon its 2003 cost report filing or the rate in
243 effect for the period ending June 30, 2005. Such rate shall then be
244 increased by eleven dollars and eighty cents per day except that in no
245 event shall the rate for the period ending June 30, 2006, be thirty-two
246 dollars more than the rate in effect for the period ending June 30, 2005,
247 and for any facility with a rate below one hundred ninety-five dollars
248 per day for the period ending June 30, 2005, such rate for the period
249 ending June 30, 2006, shall not be greater than two hundred seventeen
250 dollars and forty-three cents per day and for any facility with a rate
251 equal to or greater than one hundred ninety-five dollars per day for
252 the period ending June 30, 2005, such rate for the period ending June
253 30, 2006, shall not exceed the rate in effect for the period ending June
254 30, 2005, increased by eleven and one-half per cent. For each facility
255 with an interim rate for the period ending June 30, 2005, the interim

256 replacement rate for the period ending June 30, 2006, shall not exceed
257 the rate in effect for the period ending June 30, 2005, increased by
258 eleven dollars and eighty cents per day plus the per day cost of the
259 user fee payments made pursuant to section 17b-320 divided by
260 annual resident service days, except for any facility with an interim
261 rate below one hundred ninety-five dollars per day for the period
262 ending June 30, 2005, the interim replacement rate for the period
263 ending June 30, 2006, shall not be greater than two hundred seventeen
264 dollars and forty-three cents per day and for any facility with an
265 interim rate equal to or greater than one hundred ninety-five dollars
266 per day for the period ending June 30, 2005, the interim replacement
267 rate for the period ending June 30, 2006, shall not exceed the rate in
268 effect for the period ending June 30, 2005, increased by eleven and one-
269 half per cent. Such July 1, 2005, rate adjustments shall remain in effect
270 unless (i) the federal financial participation matching funds associated
271 with the rate increase are no longer available; or (ii) the user fee
272 created pursuant to section 17b-320 is not in effect. For the fiscal year
273 ending June 30, 2007, each facility shall receive a rate that is three per
274 cent greater than the rate in effect for the period ending June 30, 2006,
275 except any facility that would have been issued a lower rate effective
276 July 1, 2006, than for the rate period ending June 30, 2006, due to
277 interim rate status or agreement with the department, shall be issued
278 such lower rate effective July 1, 2006. For the fiscal year ending June
279 30, 2008, each facility shall receive a rate that is two and nine-tenths
280 per cent greater than the rate in effect for the period ending June 30,
281 2007, except any facility that would have been issued a lower rate
282 effective July 1, 2007, than for the rate period ending June 30, 2007, due
283 to interim rate status or agreement with the department, shall be
284 issued such lower rate effective July 1, 2007. For the fiscal year ending
285 June 30, 2009, rates in effect for the period ending June 30, 2008, shall
286 remain in effect until June 30, 2009, except any facility that would have
287 been issued a lower rate for the fiscal year ending June 30, 2009, due to
288 interim rate status or agreement with the department shall be issued
289 such lower rate. For the fiscal years ending June 30, 2010, and June 30,
290 2011, rates in effect for the period ending June 30, 2009, shall remain in

291 effect until June 30, 2011, except any facility that would have been
292 issued a lower rate for the fiscal year ending June 30, 2010, or the fiscal
293 year ending June 30, 2011, due to interim rate status or agreement with
294 the department, shall be issued such lower rate. For the fiscal years
295 ending June 30, 2012, and June 30, 2013, rates in effect for the period
296 ending June 30, 2011, shall remain in effect until June 30, 2013, except
297 any facility that would have been issued a lower rate for the fiscal year
298 ending June 30, 2012, or the fiscal year ending June 30, 2013, due to
299 interim rate status or agreement with the department, shall be issued
300 such lower rate. For the fiscal years ending June 30, 2014, and June 30,
301 2015, rates shall not exceed those in effect for the period ending June
302 30, 2013. Any facility that would have been issued a lower rate for the
303 fiscal year ending June 30, 2014, or the fiscal year ending June 30, 2015,
304 due to rebasing, available appropriations, interim rate status or
305 agreement with the department, shall be issued such lower rate. The
306 Commissioner of Social Services shall add fair rent increases to any
307 other rate increases established pursuant to this subdivision for a
308 facility which has undergone a material change in circumstances
309 related to fair rent, except for the fiscal years ending June 30, 2010, June
310 30, 2011, and June 30, 2012, such fair rent increases shall only be
311 provided to facilities with an approved certificate of need pursuant to
312 section 17b-352, 17b-353, 17b-354 or 17b-355. For the fiscal year ending
313 June 30, 2013, the commissioner may, within available appropriations,
314 provide pro rata fair rent increases for facilities which have undergone
315 a material change in circumstances related to fair rent additions placed
316 in service in cost report years ending September 30, 2008, to September
317 30, 2011, inclusive, and not otherwise included in rates issued. For the
318 fiscal year ending June 30, 2013, the commissioner shall add fair rent
319 increases associated with an approved certificate of need pursuant to
320 section 17b-352, 17b-353, 17b-354 or 17b-355. Interim rates may take
321 into account reasonable costs incurred by a facility, including wages
322 and benefits. Notwithstanding the provisions of this section, the
323 Commissioner of Social Services may, [within] subject to available
324 appropriations, increase or decrease rates issued to licensed chronic
325 and convalescent nursing homes and licensed rest homes with nursing

326 supervision.

327 Sec. 4. Subdivision (1) of subsection (h) of section 17b-340 of the
328 general statutes is repealed and the following is substituted in lieu
329 thereof (*Effective July 1, 2013*):

330 (h) (1) For the fiscal year ending June 30, 1993, any residential care
331 home with an operating cost component of its rate in excess of one
332 hundred thirty per cent of the median of operating cost components of
333 rates in effect January 1, 1992, shall not receive an operating cost
334 component increase. For the fiscal year ending June 30, 1993, any
335 residential care home with an operating cost component of its rate that
336 is less than one hundred thirty per cent of the median of operating cost
337 components of rates in effect January 1, 1992, shall have an allowance
338 for real wage growth equal to sixty-five per cent of the increase
339 determined in accordance with subsection (q) of section 17-311-52 of
340 the regulations of Connecticut state agencies, provided such operating
341 cost component shall not exceed one hundred thirty per cent of the
342 median of operating cost components in effect January 1, 1992.
343 Beginning with the fiscal year ending June 30, 1993, for the purpose of
344 determining allowable fair rent, a residential care home with allowable
345 fair rent less than the twenty-fifth percentile of the state-wide
346 allowable fair rent shall be reimbursed as having allowable fair rent
347 equal to the twenty-fifth percentile of the state-wide allowable fair
348 rent. Beginning with the fiscal year ending June 30, 1997, a residential
349 care home with allowable fair rent less than three dollars and ten cents
350 per day shall be reimbursed as having allowable fair rent equal to
351 three dollars and ten cents per day. Property additions placed in
352 service during the cost year ending September 30, 1996, or any
353 succeeding cost year shall receive a fair rent allowance for such
354 additions as an addition to three dollars and ten cents per day if the
355 fair rent for the facility for property placed in service prior to
356 September 30, 1995, is less than or equal to three dollars and ten cents
357 per day. For the fiscal year ending June 30, 1996, and any succeeding
358 fiscal year, the allowance for real wage growth, as determined in

359 accordance with subsection (q) of section 17-311-52 of the regulations
360 of Connecticut state agencies, shall not be applied. For the fiscal year
361 ending June 30, 1996, and any succeeding fiscal year, the inflation
362 adjustment made in accordance with subsection (p) of section 17-311-
363 52 of the regulations of Connecticut state agencies shall not be applied
364 to real property costs. Beginning with the fiscal year ending June 30,
365 1997, minimum allowable patient days for rate computation purposes
366 for a residential care home with twenty-five beds or less shall be
367 eighty-five per cent of licensed capacity. Beginning with the fiscal year
368 ending June 30, 2002, for the purposes of determining the allowable
369 salary of an administrator of a residential care home with sixty beds or
370 less the department shall revise the allowable base salary to thirty-
371 seven thousand dollars to be annually inflated thereafter in accordance
372 with section 17-311-52 of the regulations of Connecticut state agencies.
373 The rates for the fiscal year ending June 30, 2002, shall be based upon
374 the increased allowable salary of an administrator, regardless of
375 whether such amount was expended in the 2000 cost report period
376 upon which the rates are based. Beginning with the fiscal year ending
377 June 30, 2000, and until the fiscal year ending June 30, 2009, inclusive,
378 the inflation adjustment for rates made in accordance with subsection
379 (p) of section 17-311-52 of the regulations of Connecticut state agencies
380 shall be increased by two per cent, and beginning with the fiscal year
381 ending June 30, 2002, the inflation adjustment for rates made in
382 accordance with subsection (c) of said section shall be increased by one
383 per cent. Beginning with the fiscal year ending June 30, 1999, for the
384 purpose of determining the allowable salary of a related party, the
385 department shall revise the maximum salary to twenty-seven
386 thousand eight hundred fifty-six dollars to be annually inflated
387 thereafter in accordance with section 17-311-52 of the regulations of
388 Connecticut state agencies and beginning with the fiscal year ending
389 June 30, 2001, such allowable salary shall be computed on an hourly
390 basis and the maximum number of hours allowed for a related party
391 other than the proprietor shall be increased from forty hours to forty-
392 eight hours per work week. For the fiscal year ending June 30, 2005,
393 each facility shall receive a rate that is two and one-quarter per cent

394 more than the rate the facility received in the prior fiscal year, except
395 any facility that would have been issued a lower rate effective July 1,
396 2004, than for the fiscal year ending June 30, 2004, due to interim rate
397 status or agreement with the department shall be issued such lower
398 rate effective July 1, 2004. Effective upon receipt of all the necessary
399 federal approvals to secure federal financial participation matching
400 funds associated with the rate increase provided in subdivision (4) of
401 subsection (f) of this section, but in no event earlier than October 1,
402 2005, and provided the user fee imposed under section 17b-320 is
403 required to be collected, each facility shall receive a rate that is
404 determined in accordance with applicable law and subject to
405 appropriations, except any facility that would have been issued a
406 lower rate effective October 1, 2005, than for the fiscal year ending June
407 30, 2005, due to interim rate status or agreement with the department,
408 shall be issued such lower rate effective October 1, 2005. Such rate
409 increase shall remain in effect unless: (A) The federal financial
410 participation matching funds associated with the rate increase are no
411 longer available; or (B) the user fee created pursuant to section 17b-320
412 is not in effect. For the fiscal year ending June 30, 2007, rates in effect
413 for the period ending June 30, 2006, shall remain in effect until
414 September 30, 2006, except any facility that would have been issued a
415 lower rate effective July 1, 2006, than for the fiscal year ending June 30,
416 2006, due to interim rate status or agreement with the department,
417 shall be issued such lower rate effective July 1, 2006. Effective October
418 1, 2006, no facility shall receive a rate that is more than four per cent
419 greater than the rate in effect for the facility on September 30, 2006,
420 except for any facility that would have been issued a lower rate
421 effective October 1, 2006, due to interim rate status or agreement with
422 the department, shall be issued such lower rate effective October 1,
423 2006. For the fiscal years ending June 30, 2010, and June 30, 2011, rates
424 in effect for the period ending June 30, 2009, shall remain in effect until
425 June 30, 2011, except any facility that would have been issued a lower
426 rate for the fiscal year ending June 30, 2010, or the fiscal year ending
427 June 30, 2011, due to interim rate status or agreement with the
428 department, shall be issued such lower rate, except (i) any facility that

429 would have been issued a lower rate for the fiscal year ending June 30,
430 2010, or the fiscal year ending June 30, 2011, due to interim rate status
431 or agreement with the Commissioner of Social Services shall be issued
432 such lower rate; and (ii) the commissioner may increase a facility's rate
433 for reasonable costs associated with such facility's compliance with the
434 provisions of section 19a-495a concerning the administration of
435 medication by unlicensed personnel. For the fiscal year ending June 30,
436 2012, rates in effect for the period ending June 30, 2011, shall remain in
437 effect until June 30, 2012, except that (I) any facility that would have
438 been issued a lower rate for the fiscal year ending June 30, 2012, due to
439 interim rate status or agreement with the Commissioner of Social
440 Services shall be issued such lower rate; and (II) the commissioner may
441 increase a facility's rate for reasonable costs associated with such
442 facility's compliance with the provisions of section 19a-495a
443 concerning the administration of medication by unlicensed personnel.
444 For the fiscal year ending June 30, 2013, the Commissioner of Social
445 Services may, within available appropriations, provide a rate increase
446 to a residential care home. Any facility that would have been issued a
447 lower rate for the fiscal year ending June 30, 2013, due to interim rate
448 status or agreement with the Commissioner of Social Services shall be
449 issued such lower rate. For the fiscal years ending June 30, 2012, and
450 June 30, 2013, the Commissioner of Social Services may provide fair
451 rent increases to any facility that has undergone a material change in
452 circumstances related to fair rent and has an approved certificate of
453 need pursuant to section 17b-352, 17b-353, 17b-354 or 17b-355. Any
454 facility that would have been issued a lower rate for the fiscal year
455 ending June 30, 2014, or the fiscal year ending June 30, 2015, due to
456 interim rate status or agreement with the commissioner, shall be issued
457 such lower rate. The department may, within available appropriations,
458 increase or decrease residential care home rates to reflect the rebasing
459 of facility costs as provided in subsection (a) of this section.

460 Sec. 5. (NEW) (*Effective October 1, 2014*) The Commissioner of Social
461 Services shall implement the tenth revision of the International
462 Statistical Classification of Diseases and Related Health Problems for

463 the purposes of all medical assistance programs administered by the
464 Department of Social Services. The Commissioner of Social Services
465 may implement policies and procedures necessary to carry out the
466 provisions of this section while in the process of adopting the policies
467 and procedures as regulations, provided notice of intent to adopt the
468 regulations is published in the Connecticut Law Journal not later than
469 twenty days after the date of implementation.

470 Sec. 6. Section 17b-239 of the general statutes is repealed and the
471 following is substituted in lieu thereof (*Effective July 1, 2013*):

472 (a) [The rate to be paid by the state to hospitals receiving
473 appropriations granted by the General Assembly and to freestanding
474 chronic disease hospitals, providing services to persons aided or cared
475 for by the state for routine services furnished to state patients, shall be
476 based upon reasonable cost to such hospital, or the charge to the
477 general public for ward services or the lowest charge for semiprivate
478 services if the hospital has no ward facilities, imposed by such
479 hospital, whichever is lowest, except to the extent, if any, that the
480 commissioner determines that a greater amount is appropriate in the
481 case of hospitals serving a disproportionate share of indigent patients.
482 Such rate shall be promulgated annually by the Commissioner of
483 Social Services.] On and after July 1, 2013, Medicaid rates paid to acute
484 care and children's hospitals shall be based on diagnosis-related
485 groups established and periodically rebased by the Commissioner of
486 Social Services, provided the Department of Social Services completes
487 a fiscal analysis of the impact of such rate payment system on each
488 hospital. The Commissioner of Social Services shall, in accordance with
489 the provisions of section 11-4a, file a report on the results of the fiscal
490 analysis not later than December 31, 2013, with the joint standing
491 committees of the General Assembly having cognizance of matters
492 relating to human services and appropriations and the budgets of state
493 agencies. The Commissioner of Social Services shall annually
494 determine inpatient rates for each hospital by multiplying diagnostic-
495 related group relative weights by a base rate. Within available

496 appropriations, the commissioner may, in his or her discretion, make
497 additional payments to hospitals based on criteria to be determined by
498 the commissioner. Nothing contained in this section shall authorize [a]
499 Medicaid payment by the state [for such services] to any such hospital
500 in excess of the charges made by such hospital for comparable services
501 to the general public. [Notwithstanding the provisions of this section,
502 for the rate period beginning July 1, 2000, rates paid to freestanding
503 chronic disease hospitals and freestanding psychiatric hospitals shall
504 be increased by three per cent. For the rate period beginning July 1,
505 2001, a freestanding chronic disease hospital or freestanding
506 psychiatric hospital shall receive a rate that is two and one-half per
507 cent more than the rate it received in the prior fiscal year and such rate
508 shall remain effective until December 31, 2002. Effective January 1,
509 2003, a freestanding chronic disease hospital or freestanding
510 psychiatric hospital shall receive a rate that is two per cent more than
511 the rate it received in the prior fiscal year. Notwithstanding the
512 provisions of this subsection, for the period commencing July 1, 2001,
513 and ending June 30, 2003, the commissioner may pay an additional
514 total of no more than three hundred thousand dollars annually for
515 services provided to long-term ventilator patients. For purposes of this
516 subsection, "long-term ventilator patient" means any patient at a
517 freestanding chronic disease hospital on a ventilator for a total of sixty
518 days or more in any consecutive twelve-month period. Effective July 1,
519 2007, each freestanding chronic disease hospital shall receive a rate
520 that is four per cent more than the rate it received in the prior fiscal
521 year.]

522 (b) Effective October 1, 1991, the rate to be paid by the state for the
523 cost of special services rendered by such hospitals shall be established
524 annually by the commissioner for each such hospital based on the
525 reasonable cost to each hospital of such services furnished to state
526 patients. Nothing contained in this subsection shall authorize a
527 payment by the state for such services to any such hospital in excess of
528 the charges made by such hospital for comparable services to the
529 general public.

530 (c) The term "reasonable cost" as used in this section means the cost
531 of care furnished such patients by an efficient and economically
532 operated facility, computed in accordance with accepted principles of
533 hospital cost reimbursement. The commissioner may adjust the rate of
534 payment established under the provisions of this section for the year
535 during which services are furnished to reflect fluctuations in hospital
536 costs. Such adjustment may be made prospectively to cover anticipated
537 fluctuations or may be made retroactive to any date subsequent to the
538 date of the initial rate determination for such year or in such other
539 manner as may be determined by the commissioner. In determining
540 "reasonable cost" the commissioner may give due consideration to
541 allowances for fully or partially unpaid bills, reasonable costs
542 mandated by collective bargaining agreements with certified collective
543 bargaining agents or other agreements between the employer and
544 employees, provided "employees" shall not include persons employed
545 as managers or chief administrators, requirements for working capital
546 and cost of development of new services, including additions to and
547 replacement of facilities and equipment. The commissioner shall not
548 give consideration to amounts paid by the facilities to employees as
549 salary, or to attorneys or consultants as fees, where the responsibility
550 of the employees, attorneys or consultants is to persuade or seek to
551 persuade the other employees of the facility to support or oppose
552 unionization. Nothing in this subsection shall prohibit the
553 commissioner from considering amounts paid for legal counsel related
554 to the negotiation of collective bargaining agreements, the settlement
555 of grievances or normal administration of labor relations.

556 (d) [The state shall also pay to such hospitals for each outpatient
557 clinic and emergency room visit a reasonable rate to be established
558 annually by the commissioner for each hospital, such rate to be
559 determined by the reasonable cost of such services. The emergency
560 room visit rates in effect June 30, 1991, shall remain in effect through
561 June 30, 1993, except those which would have been decreased effective
562 July 1, 1991, or July 1, 1992, shall be decreased.] On or after July 1,
563 2013, hospitals shall be paid for outpatient and emergency room

564 episodes of care based on prospective rates established by the
565 commissioner in accordance with the Medicare ambulatory payment
566 classification system in conjunction with a state conversion factor,
567 provided the Department of Social Services completes a fiscal analysis
568 of the impact of such rate payment system on each hospital. The
569 Commissioner of Social Services shall, in accordance with the
570 provisions of section 11-4a, file a report on the results of the fiscal
571 analysis not later than December 31, 2013, with the joint standing
572 committees of the General Assembly having cognizance of matters
573 relating to human services and appropriations and the budgets of state
574 agencies. The Medicare ambulatory payment classification system
575 shall be modified to provide payment for services not generally
576 covered by Medicare, including, but not limited to, pediatric, obstetric,
577 neonatal and perinatal services. Nothing contained in this subsection
578 shall authorize a payment by the state for such [services] episodes of
579 care to any hospital in excess of the charges made by such hospital for
580 comparable services to the general public. [For those] Those outpatient
581 hospital services that do not have an established Ambulatory Payment
582 Classification code shall be paid on the basis of a ratio of cost to
583 charges, [the ratios] or the fixed fee in effect [June 30, 1991, shall be
584 reduced effective July 1, 1991, by the most recent annual increase in the
585 consumer price index for medical care. For those outpatient hospital
586 services paid on the basis of a ratio of cost to charges, the ratios
587 computed to be effective July 1, 1994, shall be reduced by the most
588 recent annual increase in the consumer price index for medical care.
589 The emergency room visit rates in effect June 30, 1994, shall remain in
590 effect through December 31, 1994] as of July 1, 2014. The
591 Commissioner of Social Services shall establish a fee schedule for
592 outpatient hospital services to be effective on and after January 1, 1995,
593 and may annually modify such fee schedule if such modification is
594 needed to ensure that the conversion to an administrative services
595 organization is cost neutral to hospitals in the aggregate and ensures
596 patient access. Utilization may be a factor in determining cost
597 neutrality. [for the fiscal year ending June 30, 2013. Except with respect
598 to the rate periods beginning July 1, 1999, and July 1, 2000, such fee

599 schedule shall be adjusted annually beginning July 1, 1996, to reflect
600 necessary increases in the cost of services. Notwithstanding the
601 provisions of this subsection, the fee schedule for the rate period
602 beginning July 1, 2000, shall be increased by ten and one-half per cent,
603 effective June 1, 2001. Notwithstanding the provisions of this
604 subsection, outpatient rates in effect as of June 30, 2003, shall remain in
605 effect through June 30, 2005. Effective July 1, 2006, subject to available
606 appropriations, the commissioner shall increase outpatient service fees
607 for services that may include clinic, emergency room, magnetic
608 resonance imaging, and computerized axial tomography.]

609 (e) The commissioner shall adopt regulations, in accordance with
610 the provisions of chapter 54, establishing criteria for defining
611 emergency and nonemergency visits to hospital emergency rooms. All
612 nonemergency visits to hospital emergency rooms shall be paid at the
613 hospital's outpatient clinic services rate. Nothing contained in this
614 subsection or the regulations adopted [hereunder] under this section
615 shall authorize a payment by the state for such services to any hospital
616 in excess of the charges made by such hospital for comparable services
617 to the general public.

618 (f) [On and after October 1, 1984, the state shall pay to an acute care
619 general hospital for the inpatient care of a patient who no longer
620 requires acute care a rate determined by the following schedule: For
621 the first seven days following certification that the patient no longer
622 requires acute care the state shall pay the hospital at a rate of fifty per
623 cent of the hospital's actual cost; for the second seven-day period
624 following certification that the patient no longer requires acute care the
625 state shall pay seventy-five per cent of the hospital's actual cost; for the
626 third seven-day period following certification that the patient no
627 longer requires acute care and for any period of time thereafter, the
628 state shall pay the hospital at a rate of one hundred per cent of the
629 hospital's actual cost.] On and after July 1, 1995, no payment shall be
630 made by the state to an acute care general hospital for the inpatient
631 care of a patient who no longer requires acute care and is eligible for

632 Medicare unless the hospital does not obtain reimbursement from
633 Medicare for that stay.

634 (g) The Commissioner of Social Services may implement policies
635 and procedures necessary to carry out the provisions of this section
636 while in the process of adopting the policies and procedures as
637 regulations, provided notice of intent to adopt the regulations is
638 published in the Connecticut Law Journal not later than twenty days
639 after the date of implementation.

640 Sec. 7. Subsection (b) of section 17b-239e of the general statutes is
641 repealed and the following is substituted in lieu thereof (*Effective July*
642 *1, 2013*):

643 (b) The commissioner may establish a blended in-patient hospital
644 case rate that includes services provided to all Medicaid recipients and
645 may exclude certain diagnoses, as determined by the commissioner, if
646 the establishment of such rates is needed to ensure that the conversion
647 to an administrative services organization is cost neutral to hospitals in
648 the aggregate and ensures patient access. Utilization may be a factor in
649 determining cost neutrality. [for the fiscal year ending June 30, 2013.]

650 Sec. 8. Subsection (a) of section 17b-242 of the general statutes is
651 repealed and the following is substituted in lieu thereof (*Effective July*
652 *1, 2013*):

653 (a) The Department of Social Services shall determine the rates to be
654 paid to home health care agencies and homemaker-home health aide
655 agencies by the state or any town in the state for persons aided or
656 cared for by the state or any such town. For the period from February
657 1, 1991, to January 31, 1992, inclusive, payment for each service to the
658 state shall be based upon the rate for such service as determined by the
659 Office of Health Care Access, except that for those providers whose
660 Medicaid rates for the year ending January 31, 1991, exceed the median
661 rate, no increase shall be allowed. For those providers whose rates for
662 the year ending January 31, 1991, are below the median rate, increases

663 shall not exceed the lower of the prior rate increased by the most
664 recent annual increase in the consumer price index for urban
665 consumers or the median rate. In no case shall any such rate exceed the
666 eightieth percentile of rates in effect January 31, 1991, nor shall any rate
667 exceed the charge to the general public for similar services. Rates
668 effective February 1, 1992, shall be based upon rates as determined by
669 the Office of Health Care Access, except that increases shall not exceed
670 the prior year's rate increased by the most recent annual increase in the
671 consumer price index for urban consumers and rates effective
672 February 1, 1992, shall remain in effect through June 30, 1993. Rates
673 effective July 1, 1993, shall be based upon rates as determined by the
674 Office of Health Care Access except if the Medicaid rates for any
675 service for the period ending June 30, 1993, exceed the median rate for
676 such service, the increase effective July 1, 1993, shall not exceed one
677 per cent. If the Medicaid rate for any service for the period ending June
678 30, 1993, is below the median rate, the increase effective July 1, 1993,
679 shall not exceed the lower of the prior rate increased by one and one-
680 half times the most recent annual increase in the consumer price index
681 for urban consumers or the median rate plus one per cent. The
682 Commissioner of Social Services shall establish a fee schedule for home
683 health services to be effective on and after July 1, 1994. The
684 commissioner may annually modify such fee schedule if such
685 modification is needed to ensure that the conversion to an
686 administrative services organization is cost neutral to home health care
687 agencies and homemaker-home health aide agencies in the aggregate
688 and ensures patient access. Utilization may be a factor in determining
689 cost neutrality. [for the fiscal year ending June 30, 2013.] The
690 commissioner shall increase the fee schedule for home health services
691 provided under the Connecticut home-care program for the elderly
692 established under section 17b-342, effective July 1, 2000, by two per
693 cent over the fee schedule for home health services for the previous
694 year. The commissioner may increase any fee payable to a home health
695 care agency or homemaker-home health aide agency upon the
696 application of such an agency evidencing extraordinary costs related to
697 (1) serving persons with AIDS; (2) high-risk maternal and child health

698 care; (3) escort services; or (4) extended hour services. In no case shall
699 any rate or fee exceed the charge to the general public for similar
700 services. A home health care agency or homemaker-home health aide
701 agency which, due to any material change in circumstances, is
702 aggrieved by a rate determined pursuant to this subsection may,
703 within ten days of receipt of written notice of such rate from the
704 Commissioner of Social Services, request in writing a hearing on all
705 items of aggrievement. The commissioner shall, upon the receipt of all
706 documentation necessary to evaluate the request, determine whether
707 there has been such a change in circumstances and shall conduct a
708 hearing if appropriate. The Commissioner of Social Services shall
709 adopt regulations, in accordance with chapter 54, to implement the
710 provisions of this subsection. The commissioner may implement
711 policies and procedures to carry out the provisions of this subsection
712 while in the process of adopting regulations, provided notice of intent
713 to adopt the regulations is published in the Connecticut Law Journal
714 [within] not later than twenty days after the date of implementing the
715 policies and procedures. Such policies and procedures shall be valid
716 for not longer than nine months.

717 Sec. 9. Subsection (a) of section 17b-261m of the general statutes is
718 repealed and the following is substituted in lieu thereof (*Effective July*
719 *1, 2013*):

720 (a) The Commissioner of Social Services may contract with one or
721 more administrative services organizations to provide care
722 coordination, utilization management, disease management, customer
723 service and review of grievances for recipients of assistance under
724 Medicaid, HUSKY Plan, Parts A and B, and the Charter Oak Health
725 Plan. Such organization may also provide network management,
726 credentialing of providers, monitoring of copayments and premiums
727 and other services as required by the commissioner. Subject to
728 approval by applicable federal authority, the Department of Social
729 Services shall utilize the contracted organization's provider network
730 and billing systems in the administration of the program. In order to

731 implement the provisions of this section, the commissioner may
732 establish rates of payment to providers of medical services under this
733 section if the establishment of such rates is required to ensure that any
734 contract entered into with an administrative services organization
735 pursuant to this section is cost neutral to such providers in the
736 aggregate and ensures patient access. Utilization may be a factor in
737 determining cost neutrality. [for the fiscal year ending June 30, 2013.]

738 Sec. 10. Subsection (a) of section 17b-239c of the general statutes is
739 repealed and the following is substituted in lieu thereof (*Effective July*
740 *1, 2013*):

741 (a) Notwithstanding any provision of the general statutes, on and
742 after July 1, 2011, the Department of Social Services may, within
743 available appropriations, make interim [monthly] quarterly medical
744 assistance disproportionate share payments to short-term general
745 hospitals. The total amount of interim payments made to such
746 hospitals individually and in the aggregate shall maximize federal
747 matching payments under the medical assistance program as
748 determined by the Department of Social Services, in consultation with
749 the Office of Policy and Management. No payments shall be made
750 under this section to (1) any hospital which, on July 1, 2011, is within
751 the class of hospitals licensed by the Department of Public Health as a
752 children's general hospital, or (2) a short-term acute hospital operated
753 exclusively by the state other than a short-term acute hospital operated
754 by the state as a receiver pursuant to chapter 920. The [monthly]
755 quarterly interim payment amount for each hospital shall be
756 determined by the Commissioner of Social Services based upon the
757 information submitted by the hospital pursuant to Section 1001(d) of
758 Public Law 108-173, the Medicare Prescription Drug, Improvement,
759 and Modernization Act of 2003.

760 Sec. 11. Section 17b-28e of the general statutes is repealed and the
761 following is substituted in lieu thereof (*Effective July 1, 2013*):

762 (a) The Commissioner of Social Services shall amend the Medicaid

763 state plan to include, on and after January 1, 2009, hospice services as
764 optional services covered under the Medicaid program. Said state plan
765 amendment shall supersede any regulations of Connecticut state
766 agencies concerning such optional services. [From January 1, 2013, to
767 June 30, 2013, inclusive, hospice] Hospice services covered under the
768 Medicaid program for individuals who are residents in long-term care
769 facilities shall be paid at a rate that is ninety-five per cent of the
770 facility's per diem rate.

771 [(b) Effective July 1, 2013, the Commissioner of Social Services shall
772 amend the Medicaid state plan to include foreign language interpreter
773 services provided to any beneficiary with limited English proficiency
774 as a covered service under the Medicaid program. Not later than July
775 1, 2013, the commissioner shall develop and implement the use of
776 medical billing codes for foreign language interpreter services.

777 (c) Effective July 1, 2013, the Department of Social Services shall
778 report, in accordance with the provisions of section 11-4a, semi-
779 annually, to the Council on Medical Assistance Program Oversight on
780 the foreign language interpreter services provided to recipients of
781 benefits under the program.]

782 [(d)] (b) Not later than October 1, 2011, the Commissioner of Social
783 Services shall amend the Medicaid state plan to include podiatry as an
784 optional service under the Medicaid program.

785 [(e) The Commissioner of Social Services shall amend the Medicaid
786 state plan to provide that chiropractic services shall be covered under
787 the Medicaid program only to the extent required by federal law.]

788 Sec. 12. Section 17b-261 of the general statutes is amended by
789 adding subsection (k) as follows (*Effective January 1, 2014*):

790 (NEW) (k) In addition to persons eligible for medical assistance
791 under the provisions of subsections (a) to (j), inclusive, of this section,
792 on and after January 1, 2014, medical assistance shall be provided
793 without an asset test to low-income adults whose income does not

794 exceed one hundred thirty-three per cent of the federal poverty level,
795 in accordance with Section 1902(a)(10)(A)(i)(VIII) of the Social Security
796 Act. In determining eligibility, the commissioner shall not consider as
797 income Aid and Attendance pension benefits granted to a veteran, as
798 defined in section 27-103, or the surviving spouse of such veteran.

799 Sec. 13. Section 17b-256f of the general statutes is repealed and the
800 following is substituted in lieu thereof (*Effective January 1, 2014*):

801 [Beginning March 1, 2012, and annually thereafter, the] The
802 Commissioner of Social Services shall increase income disregards used
803 to determine eligibility by the Department of Social Services for the
804 federal [Specified Low-Income Medicare Beneficiary, the] Qualified
805 Medicare Beneficiary, the Specified Low-Income Medicare Beneficiary
806 and the Qualifying Individual [Programs] programs, administered in
807 accordance with the provisions of 42 USC 1396d(p), by [an amount that
808 equalizes the income levels and deductions used to determine
809 eligibility for said programs with income levels and deductions used
810 to determine eligibility for the ConnPACE program under subsection
811 (a) of section 17b-492] such amounts that shall result in persons with
812 income that is (1) less than two hundred eleven per cent of the federal
813 poverty level qualifying for the Qualified Medicare Beneficiary
814 program, (2) at or above two hundred eleven per cent of the federal
815 poverty level but less than two hundred thirty-one per cent of the
816 federal poverty level qualifying for the Specified Low-Income
817 Medicare Beneficiary program, and (3) at or above two hundred thirty-
818 one per cent of the federal poverty level but less than two hundred
819 forty-six per cent of the federal poverty level qualifying for the
820 Qualifying Individual program. The commissioner shall not apply an
821 asset test for eligibility under the Medicare Savings Program. The
822 commissioner shall not consider as income Aid and Attendance
823 pension benefits granted to a veteran, as defined in section 27-103, or
824 the surviving spouse of such veteran. The Commissioner of Social
825 Services, pursuant to section 17b-10, may implement policies and
826 procedures to administer the provisions of this section while in the

827 process of adopting such policies and procedures in regulation form,
828 provided the commissioner prints notice of the intent to adopt the
829 regulations in the Connecticut Law Journal not later than twenty days
830 after the date of implementation. Such policies and procedures shall be
831 valid until the time final regulations are adopted.

832 Sec. 14. Section 17b-551 of the general statutes is repealed and the
833 following is substituted in lieu thereof (*Effective January 1, 2014*):

834 Eligibility for participation in the program shall be limited to a
835 resident who is enrolled in Medicare Part B whose annual income does
836 not exceed [one hundred sixty-five per cent of the qualifying income
837 level established in the ConnPACE program, pursuant to subsection
838 (a) of section 17b-492] forty-three thousand five hundred sixty dollars
839 or if such resident has a spouse, the combined income of such resident
840 and his spouse does not exceed [one hundred sixty-five per cent of the
841 qualifying income level established in the ConnPACE program,
842 pursuant to subsection (a) of section 17b-492] fifty-eight thousand
843 seven hundred forty dollars. On January 1, 2014, and annually
844 thereafter, the commissioner shall increase the income limit established
845 under this subsection over that of the previous fiscal year to reflect the
846 annual inflation adjustment in Social Security income, if any. Each
847 such adjustment shall be determined to the nearest one hundred
848 dollars.

849 Sec. 15. Section 17b-552 of the general statutes is repealed and the
850 following is substituted in lieu thereof (*Effective January 1, 2014*):

851 (a) A health care provider shall limit charges for care, treatment,
852 service or equipment covered by Medicare Part B under Title XVIII of
853 the Social Security Act, as amended, provided to a Medicare
854 beneficiary who meets the eligibility requirements specified in section
855 17b-551, as amended by this act, to the reasonable charge for the care,
856 treatment, service or equipment provided as determined by the United
857 States Secretary of Health and Human Services. No health care
858 provider shall collect from such qualified beneficiary any amount in

859 excess of the approved reasonable charge. Any violation of this
860 subsection shall constitute grounds for the assessment of a civil
861 penalty in accordance with subdivision (6) of subsection (a) of section
862 19a-17. Any complaint alleging a violation of this section shall be made
863 to the Department of Public Health or the appropriate professional
864 licensing board or commission.

865 (b) The Commissioner of Social Services shall adopt regulations in
866 accordance with the provisions of chapter 54, necessary to administer
867 the program and to determine eligibility in accordance with the
868 provisions of section 17b-551, as amended by this act.

869 [(c) All health care providers shall accept the identification card
870 issued for the ConnPACE program pursuant to sections 17b-490 to
871 17b-498, inclusive, as a substitute for a Medicare assignment card.]

872 Sec. 16. Subsection (a) of section 17b-278i of the general statutes is
873 repealed and the following is substituted in lieu thereof (*Effective from*
874 *passage*):

875 (a) Customized wheelchairs shall be covered under the Medicaid
876 program only when a standard wheelchair [will] does not meet an
877 individual's needs as determined by the Department of Social Services.
878 [Assessment of the need for a customized wheelchair may be
879 performed by a vendor or nursing facility only if specifically requested
880 by the department.] Wheelchair repairs and parts replacements may be
881 subject to review and approval by the department. Refurbished
882 wheelchairs, parts and components shall be utilized whenever
883 practicable.

884 Sec. 17. Subsection (a) of section 17b-340c of the general statutes is
885 repealed and the following is substituted in lieu thereof (*Effective from*
886 *passage*):

887 (a) The Commissioner of Social Services may, upon the request of a
888 nursing facility providing services eligible for payment under the
889 medical assistance program, [and after consultation with the Secretary

890 of the Office of Policy and Management,] make a payment to such
891 nursing facility in advance of normal bill payment processing. Except
892 as provided in subsection (b) of this section, (1) such advance shall not
893 exceed estimated amounts due to such nursing facility for services
894 provided to eligible recipients over the most recent two-month period,
895 and (2) the commissioner shall recover such payment through
896 reductions to payments due to such nursing facility or cash receipt not
897 later than ninety days after issuance of such payment. The
898 commissioner shall take prudent measures to assure that such advance
899 payments are not provided to any nursing facility that is at risk of
900 bankruptcy or insolvency, and may execute agreements appropriate
901 for the security of repayment.

902 Sec. 18. Section 17a-22h of the general statutes is repealed and the
903 following is substituted in lieu thereof (*Effective July 1, 2013*):

904 (a) The Commissioners of Social Services, Children and Families,
905 and Mental Health and Addiction Services shall develop and
906 implement an integrated behavioral health service system for
907 Medicaid and HUSKY Plan [Parts A and] Part B members and children
908 enrolled in the voluntary services program operated by the
909 Department of Children and Families and may, at the discretion of the
910 commissioners, include: (1) Other children, adolescents and families
911 served by the Department of Children and Families or the Court
912 Support Services Division of the Judicial Branch; and (2) [Medicaid
913 recipients who are not enrolled in HUSKY Plan Part A; and (3)]
914 Charter Oak Health Plan members. The integrated behavioral health
915 service system shall be known as the Behavioral Health Partnership.
916 The Behavioral Health Partnership shall seek to increase access to
917 quality behavioral health services by: (A) Expanding individualized,
918 family-centered and community-based services; (B) maximizing
919 federal revenue to fund behavioral health services; (C) reducing
920 unnecessary use of institutional and residential services for children
921 and adults; (D) capturing and investing enhanced federal revenue and
922 savings derived from reduced residential services and increased

923 community-based services for HUSKY Plan Parts A and B recipients;
924 (E) improving administrative oversight and efficiencies; and (F)
925 monitoring individual outcomes and provider performance, taking
926 into consideration the acuity of the patients served by each provider,
927 and overall program performance.

928 (b) The Behavioral Health Partnership shall operate in accordance
929 with the financial requirements specified in this subsection. Prior to the
930 conversion of any grant-funded services to a rate-based, fee-for-service
931 payment system, the Department of Social Services, the Department of
932 Children and Families and the Department of Mental Health and
933 Addiction Services shall submit documentation verifying that the
934 proposed rates seek to cover the reasonable cost of providing services
935 to the Behavioral Health Partnership Oversight Council, established
936 pursuant to section 17a-22j, as amended by this act.

937 Sec. 19. Section 17a-22p of the general statutes is repealed and the
938 following is substituted in lieu thereof (*Effective July 1, 2013*):

939 (a) The Departments of Children and Families, Social Services and
940 Mental Health and Addiction Services shall enter into one or more
941 joint contracts or agreements with an administrative services
942 organization or organizations to perform eligibility verification,
943 utilization management, intensive care management, quality
944 management, coordination of medical and behavioral health services,
945 provider network development and management, recipient and
946 provider services and reporting.

947 (b) Claims under the Behavioral Health Partnership shall be paid by
948 the Department of Social Services' Medicaid management information
949 systems vendor, except that the Department of Children and Families
950 and the Department of Mental Health and Addiction Services may, at
951 their discretion, continue to use existing claims payment systems.

952 (c) [Administrative services organizations] An administrative
953 services organization shall authorize services, based solely on medical

954 necessity, as defined in section 17b-259b. Such organization shall use
955 guidelines established by the clinical management committee,
956 established pursuant to section 17a-22k, [Administrative services
957 organizations may make exceptions to the guidelines when requested
958 by a member, or the member's legal guardian or service provider, and
959 determined by the administrative services organization to be in the
960 best interest of the member] provided such guidelines may only be
961 used as a basis for expeditiously approving a request for services. If a
962 request for services does not meet such guidelines, an administrative
963 services organization may deny the request based solely on the request
964 not being deemed medically necessary, as defined in section 17b-259b.
965 Decisions regarding the interpretation of such guidelines shall be
966 made by the Departments of Children and Families, Social Services
967 and Mental Health and Addiction Services. No administrative services
968 organization shall have any financial incentive to approve, deny or
969 reduce services. Administrative services organizations shall ensure
970 that service providers and persons seeking services have timely access
971 to program information and timely responses to inquiries, including
972 inquiries concerning the clinical guidelines for services.

973 (d) [The] An administrative services organization for Medicaid and
974 HUSKY Plan [Parts A and] Part B shall provide or arrange for on-site
975 assistance to facilitate the appropriate placement, as soon as
976 practicable, of children with behavioral health diagnoses who the
977 administrative services organization knows to have been in an
978 emergency department for over forty-eight hours. The administrative
979 services organization shall provide or arrange for on-site assistance to
980 arrange for the discharge or appropriate placement, as soon as
981 practicable, for children who the administrative services organization
982 knows to have remained in an inpatient hospital unit for more than
983 five days longer than is medically necessary, as agreed by the
984 administrative services organization and the hospital.

985 (e) The Departments of Children and Families, Social Services and
986 Mental Health and Addiction Services shall develop, in consultation

987 with the Behavioral Health Partnership, a comprehensive plan for
988 monitoring the performance of administrative services organizations
989 which shall include data on service authorizations, individual
990 outcomes, appeals, outreach and accessibility, comments from
991 program participants compiled from written surveys and face-to-face
992 interviews.

993 (f) The Behavioral Health Partnership shall establish policies to
994 coordinate benefits received under the partnership with other benefits
995 received under Medicaid. Such policies shall specify a coordinated
996 delivery of both physical and behavioral health care. The policies shall
997 be submitted to the Behavioral Health Partnership Oversight Council
998 for review and comment.

999 Sec. 20. Section 17b-10a of the general statutes is repealed and the
1000 following is substituted in lieu thereof (*Effective January 1, 2014*):

1001 The Commissioner of Social Services, pursuant to section 17b-10,
1002 may implement policies and procedures necessary to administer
1003 section 17b-197, subsection (d) of section 17b-266, section 17b-280a [,
1004 and subsection (a) of section 17b-295, and subsection (c) of section
1005 17b-311,] while in the process of adopting such policies and procedures
1006 as regulation, provided the commissioner prints notice of intent to
1007 adopt regulations in the Connecticut Law Journal not later than twenty
1008 days after the date of implementation. Policies and procedures
1009 implemented pursuant to this section shall be valid until the time final
1010 regulations are adopted.

1011 Sec. 21. Subsection (b) of section 38a-556a of the general statutes is
1012 repealed and the following is substituted in lieu thereof (*Effective*
1013 *January 1, 2014*):

1014 (b) Said association shall, in consultation with the Insurance
1015 Commissioner and the Healthcare Advocate, develop, within available
1016 appropriations, a web site, telephone number or other method to serve
1017 as a clearinghouse for information about individual and small

1018 employer health insurance policies and health care plans that are
 1019 available to consumers in this state, including, but not limited to, the
 1020 Medicaid program, the HUSKY Plan, [the Charter Oak Health Plan set
 1021 forth in section 17b-311,] the Municipal Employee Health Insurance
 1022 Plan set forth in subsection (i) of section 5-259, and any individual or
 1023 small employer health insurance policies or health care plans an
 1024 insurer, health care center or other entity chooses to list with the
 1025 Connecticut Clearinghouse.

1026 Sec. 22. Subsection (a) of section 29-1s of the general statutes is
 1027 repealed and the following is substituted in lieu thereof (*Effective*
 1028 *January 1, 2014*):

1029 (a) (1) Wherever the term "Department of Public Safety" is used in
 1030 the following general statutes, the term "Department of Emergency
 1031 Services and Public Protection" shall be substituted in lieu thereof; and
 1032 (2) wherever the term "Commissioner of Public Safety" is used in the
 1033 following general statutes, the term "Commissioner of Emergency
 1034 Services and Public Protection" shall be substituted in lieu thereof: 1-
 1035 24, 1-84b, 1-217, 2-90b, 3-2b, 4-68m, 4a-2a, 4a-18, 4a-67d, 4b-1, 4b-130, 5-
 1036 142, 5-146, 5-149, 5-150, 5-169, 5-173, 5-192f, 5-192t, 5-246, 6-32g, 7-169,
 1037 7-285, 7-294f to 7-294h, inclusive, 7-294l, 7-294n, 7-294y, 7-425, 9-7a, 10-
 1038 233h, 12-562, 12-564a, 12-586f, 12-586g, 13a-123, 13b-69, 13b-376, 14-10,
 1039 14-64, 14-67m, 14-67w, 14-103, 14-108a, 14-138, 14-152, 14-163c, 14-211a,
 1040 14-212a, 14-212f, 14-219c, 14-227a, 14-227c, 14-267a, 14-270c to 14-270f,
 1041 inclusive, 14-283, 14-291, 14-298, 14-315, 15-98, 15-140r, 15-140u, 16-
 1042 256g, 16a-103, 17a-105a, 17a-106a, 17a-500, 17b-90, as amended by this
 1043 act, 17b-137, 17b-192, 17b-225, 17b-279, [17b-490,] 18-87k, 19a-112a, 19a-
 1044 112f, 19a-179b, 19a-409, 19a-904, 20-12c, 20-327b, 21a-36, 21a-283, 22a-2,
 1045 23-8b, 23-18, 26-5, 26-67b, 27-19a, 27-107, 28-25b, 28-27, 28-27a, 28-30a,
 1046 29-1c, 29-1e to 29-1h, inclusive, 29-1q, 29-1zz, 29-2, 29-2a, 29-2b, 29-3a,
 1047 29-4a, 29-6a, 29-7, 29-7b, 29-7c, 29-7h, 29-7m, 29-7n, 29-8, 29-10, 29-10a,
 1048 29-10c, 29-11, 29-12, 29-17a, 29-17b, 29-17c, 29-18 to 29-23a, inclusive,
 1049 29-25, 29-26, 29-28, 29-28a, 29-30 to 29-32, inclusive, 29-32b, 29-33, 29-
 1050 36f to 29-36i, inclusive, 29-36k, 29-36m, 29-36n, 29-37a, 29-37f, 29-38b,

1051 29-38e, 29-38f, 29-108b, 29-143i, 29-143j, 29-145 to 29-151, inclusive, 29-
 1052 152f to 29-152j, inclusive, 29-152m, 29-152o, 29-152u, 29-153, 29-155d,
 1053 29-156a, 29-161g to 29-161i, inclusive, 29-161k to 29-161m, inclusive, 29-
 1054 161o to 29-161t, inclusive, 29-161v to 29-161z, inclusive, 29-163, 29-
 1055 164g, 29-166, 29-176 to 29-179, inclusive, 29-179f to 29-179h, 31-275,
 1056 38a-18, 38a-356, 45a-63, 46a-4b, 46a-170, 46b-15a, 46b-38d, 46b-38f, 51-
 1057 5c, 51-10c, 51-51o, 51-277a, 52-11, 53-39a, 53-134, 53-199, 53-202, 53-
 1058 202b, 53-202c, 53-202g, 53-202l, 53-202n, 53-202o, 53-278c, 53-341b, 53a-
 1059 3, 53a-30, 53a-54b, 53a-130, 53a-130a, 54-1f, 54-1l, 54-36e, 54-36i, 54-36n,
 1060 54-47aa, 54-63c, 54-76l, 54-86k, 54-102g to 54-102j, inclusive, 54-102m,
 1061 54-102pp, 54-142j, 54-222a, 54-240, 54-240m, 54-250 to 54-258, inclusive,
 1062 54-259a, 54-260b, and 54-300.

1063 Sec. 23. Subsection (e) of section 12-746 of the general statutes is
 1064 repealed and the following is substituted in lieu thereof (*Effective*
 1065 *January 1, 2014*):

1066 (e) Amounts rebated pursuant to this section shall not be considered
 1067 income for purposes of sections 8-119l, 12-170d, 12-170aa, [17b-490,]
 1068 17b-550, 17b-812, 47-88d and 47-287.

1069 Sec. 24. Subsection (b) of section 10a-132e of the general statutes is
 1070 repealed and the following is substituted in lieu thereof (*Effective*
 1071 *January 1, 2014*):

1072 (b) The program established pursuant to subsection (a) of this
 1073 section shall: (1) Arrange for licensed physicians, pharmacists and
 1074 nurses to conduct in person educational visits with prescribing
 1075 practitioners, utilizing evidence-based materials, borrowing methods
 1076 from behavioral science and educational theory and, when
 1077 appropriate, utilizing pharmaceutical industry data and outreach
 1078 techniques; (2) inform prescribing practitioners about drug marketing
 1079 that is designed to prevent competition to brand name drugs from
 1080 generic or other therapeutically-equivalent pharmaceutical alternatives
 1081 or other evidence-based treatment options; and (3) provide outreach
 1082 and education to licensed physicians and other health care

1083 practitioners who are participating providers in state-funded health
1084 care programs, including, but not limited to, Medicaid, the HUSKY
1085 Plan, Parts A and B, [the Charter Oak Health Plan, the ConnPACE
1086 program,] the Department of Correction inmate health services
1087 program and the state employees' health insurance plan.

1088 Sec. 25. Subsection (a) of section 17a-22f of the general statutes is
1089 repealed and the following is substituted in lieu thereof (*Effective*
1090 *January 1, 2014*):

1091 (a) The Commissioner of Social Services may, with regard to the
1092 provision of behavioral health services provided pursuant to a state
1093 plan under Title XIX or Title XXI of the Social Security Act; [, or under
1094 the Charter Oak Health Plan:] (1) Contract with one or more
1095 administrative services organizations to provide clinical management,
1096 provider network development and other administrative services; (2)
1097 delegate responsibility to the Department of Children and Families for
1098 the clinical management portion of such administrative contract or
1099 contracts that pertain to HUSKY Plan Parts A and B, and other
1100 children, adolescents and families served by the Department of
1101 Children and Families; and (3) delegate responsibility to the
1102 Department of Mental Health and Addiction Services for the clinical
1103 management portion of such administrative contract or contracts that
1104 pertain to Medicaid recipients who are not enrolled in HUSKY Plan
1105 Part A. [and recipients enrolled in the Charter Oak Health Plan.]

1106 Sec. 26. Subsection (a) of section 17a-22h of the general statutes, as
1107 amended by section 18 of this act, is repealed and the following is
1108 substituted in lieu thereof (*Effective January 1, 2014*):

1109 (a) The Commissioners of Social Services, Children and Families,
1110 and Mental Health and Addiction Services shall develop and
1111 implement an integrated behavioral health service system for
1112 Medicaid and HUSKY Plan Part B members and children enrolled in
1113 the voluntary services program operated by the Department of
1114 Children and Families and may, at the discretion of the commissioners,

1115 include [:(1) Other] other children, adolescents and families served by
1116 the Department of Children and Families or the Court Support
1117 Services Division of the Judicial Branch. [; and (2) Charter Oak Health
1118 Plan members.] The integrated behavioral health service system shall
1119 be known as the Behavioral Health Partnership. The Behavioral Health
1120 Partnership shall seek to increase access to quality behavioral health
1121 services by: (A) Expanding individualized, family-centered and
1122 community-based services; (B) maximizing federal revenue to fund
1123 behavioral health services; (C) reducing unnecessary use of
1124 institutional and residential services for children and adults; (D)
1125 capturing and investing enhanced federal revenue and savings derived
1126 from reduced residential services and increased community-based
1127 services for HUSKY Plan Parts A and B recipients; (E) improving
1128 administrative oversight and efficiencies; and (F) monitoring
1129 individual outcomes and provider performance, taking into
1130 consideration the acuity of the patients served by each provider, and
1131 overall program performance.

1132 Sec. 27. Subsection (a) of section 17b-28 of the general statutes is
1133 repealed and the following is substituted in lieu thereof (*Effective*
1134 *January 1, 2014*):

1135 (a) There is established a Council on Medical Assistance Program
1136 Oversight which shall advise the Commissioner of Social Services on
1137 the planning and implementation of the health care delivery system
1138 for the following health care programs: The HUSKY Plan, Parts A and
1139 B [, the Charter Oak Health Plan] and the Medicaid program,
1140 including, but not limited to, the portions of the program serving low
1141 income adults, the aged, blind and disabled individuals, individuals
1142 who are dually eligible for Medicaid and Medicare and individuals
1143 with preexisting medical conditions. The council shall monitor
1144 planning and implementation of matters related to Medicaid care
1145 management initiatives including, but not limited to, (1) eligibility
1146 standards, (2) benefits, (3) access, (4) quality assurance, (5) outcome
1147 measures, and (6) the issuance of any request for proposal by the

1148 Department of Social Services for utilization of an administrative
1149 services organization in connection with such initiatives.

1150 Sec. 28. Subsection (a) of section 17b-261m of the general statutes, as
1151 amended by section 9 of this act, is repealed and the following is
1152 substituted in lieu thereof (*Effective January 1, 2014*):

1153 (a) The Commissioner of Social Services may contract with one or
1154 more administrative services organizations to provide care
1155 coordination, utilization management, disease management, customer
1156 service and review of grievances for recipients of assistance under
1157 Medicaid [] and HUSKY Plan, Parts A and B, [] and the Charter Oak
1158 Health Plan.] Such organization may also provide network
1159 management, credentialing of providers, monitoring of copayments
1160 and premiums and other services as required by the commissioner.
1161 Subject to approval by applicable federal authority, the Department of
1162 Social Services shall utilize the contracted organization's provider
1163 network and billing systems in the administration of the program. In
1164 order to implement the provisions of this section, the commissioner
1165 may establish rates of payment to providers of medical services under
1166 this section if the establishment of such rates is required to ensure that
1167 any contract entered into with an administrative services organization
1168 pursuant to this section is cost neutral to such providers in the
1169 aggregate and ensures patient access. Utilization may be a factor in
1170 determining cost neutrality.

1171 Sec. 29. Section 17b-274 of the general statutes is repealed and the
1172 following is substituted in lieu thereof (*Effective January 1, 2014*):

1173 (a) The Division of Criminal Justice shall periodically investigate
1174 pharmacies to ensure that the state is not billed for a brand name drug
1175 product when a less expensive generic substitute drug product is
1176 dispensed to a Medicaid recipient. The Commissioner of Social
1177 Services shall cooperate and provide information as requested by such
1178 division.

1179 (b) A licensed medical practitioner may specify in writing or by a
1180 telephonic or electronic communication that there shall be no
1181 substitution for the specified brand name drug product in any
1182 prescription for a Medicaid [or ConnPACE] recipient, provided (1) the
1183 practitioner specifies the basis on which the brand name drug product
1184 and dosage form is medically necessary in comparison to a chemically
1185 equivalent generic drug product substitution, and (2) the phrase
1186 "brand medically necessary" shall be in the practitioner's handwriting
1187 on the prescription form or, if the prohibition was communicated by
1188 telephonic communication, in the pharmacist's handwriting on such
1189 form, and shall not be preprinted or stamped or initialed on such form.
1190 If the practitioner specifies by telephonic communication that there
1191 shall be no substitution for the specified brand name drug product in
1192 any prescription for a Medicaid [or ConnPACE] recipient, written
1193 certification in the practitioner's handwriting bearing the phrase
1194 "brand medically necessary" shall be sent to the dispensing pharmacy
1195 within ten days. A pharmacist shall dispense a generically equivalent
1196 drug product for any drug listed in accordance with the Code of
1197 Federal Regulations Title 42 Part 447.332 for a drug prescribed for a
1198 Medicaid, or state-administered general assistance [, or ConnPACE]
1199 recipient unless the phrase "brand medically necessary" is ordered in
1200 accordance with this subsection and such pharmacist has received
1201 approval to dispense the brand name drug product in accordance with
1202 subsection (c) of this section.

1203 (c) The Commissioner of Social Services shall implement a
1204 procedure by which a pharmacist shall obtain approval from an
1205 independent pharmacy consultant acting on behalf of the Department
1206 of Social Services, under an administrative services only contract,
1207 whenever the pharmacist dispenses a brand name drug product to a
1208 Medicaid [or ConnPACE] recipient and a chemically equivalent
1209 generic drug product substitution is available. The length of
1210 authorization for brand name drugs shall be in accordance with section
1211 17b-491a. In cases where the brand name drug is less costly than the
1212 chemically equivalent generic drug when factoring in manufacturers'

1213 rebates, the pharmacist shall dispense the brand name drug. If such
1214 approval is not granted or denied within two hours of receipt by the
1215 commissioner of the request for approval, it shall be deemed granted.
1216 Notwithstanding any provision of this section, a pharmacist shall not
1217 dispense any initial maintenance drug prescription for which there is a
1218 chemically equivalent generic substitution that is for less than fifteen
1219 days without the department's granting of prior authorization,
1220 provided prior authorization shall not otherwise be required for
1221 atypical antipsychotic drugs if the individual is currently taking such
1222 drug at the time the pharmacist receives the prescription. The
1223 pharmacist may appeal a denial of reimbursement to the department
1224 based on the failure of such pharmacist to substitute a generic drug
1225 product in accordance with this section.

1226 (d) A licensed medical practitioner shall disclose to the Department
1227 of Social Services or such consultant, upon request, the basis on which
1228 the brand name drug product and dosage form is medically necessary
1229 in comparison to a chemically equivalent generic drug product
1230 substitution. The Commissioner of Social Services shall establish a
1231 procedure by which such a practitioner may appeal a determination
1232 that a chemically equivalent generic drug product substitution is
1233 required for a Medicaid [or ConnPACE] recipient.

1234 Sec. 30. Section 17b-274a of the general statutes is repealed and the
1235 following is substituted in lieu thereof (*Effective January 1, 2014*):

1236 The Commissioner of Social Services may establish maximum
1237 allowable costs to be paid under the Medicaid [, ConnPACE] and
1238 Connecticut AIDS drug assistance programs for generic prescription
1239 drugs based on, but not limited to, actual acquisition costs. The
1240 department shall implement and maintain a procedure to review and
1241 update the maximum allowable cost list at least annually, and shall
1242 report annually to the joint standing committee of the General
1243 Assembly having cognizance of matters relating to appropriations and
1244 the budgets of state agencies on its activities pursuant to this section.

1245 Sec. 31. Subsection (a) of section 17b-274c of the general statutes is
1246 repealed and the following is substituted in lieu thereof (*Effective*
1247 *January 1, 2014*):

1248 (a) The Commissioner of Social Services may establish a voluntary
1249 mail order option for any maintenance prescription drug covered
1250 under the Medicaid [, ConnPACE] or Connecticut AIDS drug
1251 assistance programs.

1252 Sec. 32. Subsection (e) of section 17b-274d of the general statutes is
1253 repealed and the following is substituted in lieu thereof (*Effective*
1254 *January 1, 2014*):

1255 (e) The Department of Social Services, in consultation with the
1256 Pharmaceutical and Therapeutics Committee, may adopt a preferred
1257 drug [lists] list for use in the Medicaid [and ConnPACE programs]
1258 program. To the extent feasible, the department shall review all drugs
1259 included on the preferred drug [lists] list at least every twelve months,
1260 and may recommend additions to, and deletions from, the preferred
1261 drug [lists] list, to ensure that the preferred drug [lists provide] list
1262 provides for medically appropriate drug therapies for Medicaid [and
1263 ConnPACE] patients. [For the fiscal year ending June 30, 2004, such
1264 drug lists shall be limited to use in the Medicaid and ConnPACE
1265 programs and cover three classes of drugs, including proton pump
1266 inhibitors and two other classes of drugs determined by the
1267 Commissioner of Social Services. Not later than June 30, 2005, the] The
1268 Department of Social Services, in consultation with the Pharmaceutical
1269 and [Therapeutic] Therapeutics Committee, shall expand such drug
1270 [lists] list to include other classes of drugs, except as provided in
1271 subsection (f) of this section, in order to achieve savings reflected in the
1272 amounts appropriated to the department, for the various components
1273 of the program, in the state budget act.

1274 Sec. 33. Section 17b-274e of the general statutes is repealed and the
1275 following is substituted in lieu thereof (*Effective January 1, 2014*):

1276 A pharmacist, when filling a prescription under the Medicaid [,
1277 ConnPACE] or Connecticut AIDS drug assistance programs, shall fill
1278 such prescription utilizing the most cost-efficient dosage, consistent
1279 with the prescription of a prescribing practitioner as defined in section
1280 20-571, unless such pharmacist receives permission to do otherwise
1281 pursuant to the prior authorization requirements set forth in sections
1282 17b-274, as amended by this act, and 17b-491a.

1283 Sec. 34. Subsection (a) of section 17b-280 of the general statutes is
1284 repealed and the following is substituted in lieu thereof (*Effective*
1285 *January 1, 2014*):

1286 (a) The state shall reimburse for all legend drugs provided under
1287 medical assistance programs administered by the Department of Social
1288 Services at the lower of (1) the rate established by the Centers for
1289 Medicare and Medicaid Services as the federal acquisition cost, (2) the
1290 average wholesale price minus sixteen per cent, or (3) an equivalent
1291 percentage as established under the Medicaid state plan.
1292 Notwithstanding the provisions of this section, contingent upon
1293 federal approval, on and after October 1, 2012, for independent
1294 pharmacies, the state shall reimburse for such legend drugs at the
1295 lower of (A) the rate established by the Centers for Medicare and
1296 Medicaid Services as the federal acquisition cost, (B) the average
1297 wholesale price minus fifteen per cent, or (C) an equivalent percentage
1298 as established under the Medicaid state plan. The state shall pay a
1299 professional fee of one dollar and seventy cents to licensed pharmacies
1300 for each prescription dispensed to a recipient of benefits under a
1301 medical assistance program administered by the Department of Social
1302 Services in accordance with federal regulations. On and after
1303 September 4, 1991, payment for legend and nonlegend drugs provided
1304 to Medicaid recipients shall be based upon the actual package size
1305 dispensed. Effective October 1, 1991, reimbursement for over-the-
1306 counter drugs for such recipients shall be limited to those over-the-
1307 counter drugs and products published in the Connecticut Formulary,
1308 or the cross reference list, issued by the commissioner. The cost of all

1309 over-the-counter drugs and products provided to residents of nursing
1310 facilities, chronic disease hospitals, and intermediate care facilities for
1311 the mentally retarded shall be included in the facilities' per diem rate.
1312 Notwithstanding the provisions of this subsection, no dispensing fee
1313 shall be issued for a prescription drug dispensed to a [ConnPACE or]
1314 Medicaid recipient who is a Medicare Part D beneficiary when the
1315 prescription drug is a Medicare Part D drug, as defined in Public Law
1316 108-173, the Medicare Prescription Drug, Improvement, and
1317 Modernization Act of 2003.

1318 Sec. 35. Section 17b-429 of the general statutes is repealed and the
1319 following is substituted in lieu thereof (*Effective January 1, 2014*):

1320 The Commissioner of Social Services shall, within available
1321 appropriations, make information available to senior citizens and
1322 disabled persons concerning any pharmaceutical company's drug
1323 program for indigent persons by utilizing the [ConnPACE program,
1324 the] CHOICES health insurance assistance program, as defined in
1325 section 17b-427, and Infoline of Connecticut to deliver such
1326 information.

1327 Sec. 36. Section 17b-491b of the general statutes is repealed and the
1328 following is substituted in lieu thereof (*Effective January 1, 2014*):

1329 The maximum allowable cost paid for Factor VIII pharmaceuticals
1330 under the Medicaid [and ConnPACE programs] program shall be the
1331 actual acquisition cost plus eight per cent. The Commissioner of Social
1332 Services may designate specific suppliers of Factor VIII
1333 pharmaceuticals from which a dispensing pharmacy shall order the
1334 prescription to be delivered to the pharmacy and billed by the supplier
1335 to the Department of Social Services. If the commissioner so designates
1336 specific suppliers of Factor VIII pharmaceuticals, the department shall
1337 pay the dispensing pharmacy a handling fee equal to eight per cent of
1338 the actual acquisition cost for such prescription.

1339 Sec. 37. Subsection (c) of section 20-619 of the general statutes is

1340 repealed and the following is substituted in lieu thereof (*Effective*
1341 *January 1, 2014*):

1342 (c) A prescribing practitioner may specify in writing or by a
1343 telephonic or other electronic communication that there shall be no
1344 substitution for the specified brand name drug product in any
1345 prescription, provided (1) in any prescription for a Medicaid [or
1346 ConnPACE] recipient, such practitioner specifies the basis on which
1347 the brand name drug product and dosage form is medically necessary
1348 in comparison to a chemically equivalent generic name drug product
1349 substitution, and (2) the phrase "BRAND MEDICALLY NECESSARY",
1350 shall be in the practitioner's handwriting on the prescription form or
1351 on an electronically produced copy of the prescription form or, if the
1352 prohibition was communicated by telephonic or other electronic
1353 communication that did not reproduce the practitioner's handwriting,
1354 a statement to that effect appears on the form. The phrase "BRAND
1355 MEDICALLY NECESSARY" shall not be preprinted or stamped or
1356 initialed on the form. If the practitioner specifies by telephonic or other
1357 electronic communication that did not reproduce the practitioner's
1358 handwriting that there shall be no substitution for the specified brand
1359 name drug product in any prescription for a Medicaid [or ConnPACE]
1360 recipient, written certification in the practitioner's handwriting bearing
1361 the phrase "BRAND MEDICALLY NECESSARY" shall be sent to the
1362 dispensing pharmacy not later than ten days after the date of such
1363 communication.

1364 Sec. 38. Subdivision (11) of subsection (b) of section 17a-22j of the
1365 general statutes is repealed and the following is substituted in lieu
1366 thereof (*Effective January 1, 2014*):

1367 (11) One representative from each administrative services
1368 organization under contract with the Department of Social Services to
1369 provide such services for recipients of assistance under Medicaid [,]
1370 and HUSKY Plan, [Part A and Part B and the Charter Oak Health
1371 Plan,] Part B to be nonvoting ex-officio members.

1372 Sec. 39. Subsection (b) of section 17b-90 of the general statutes is
1373 repealed and the following is substituted in lieu thereof (*Effective*
1374 *January 1, 2014*):

1375 (b) No person shall, except for purposes directly connected with the
1376 administration of programs of the Department of Social Services and in
1377 accordance with the regulations of the commissioner, solicit, disclose,
1378 receive or make use of, or authorize, knowingly permit, participate in
1379 or acquiesce in the use of, any list of the names of, or any information
1380 concerning, persons applying for or receiving assistance from the
1381 Department of Social Services or persons participating in a program
1382 administered by said department, directly or indirectly derived from
1383 the records, papers, files or communications of the state or its
1384 subdivisions or agencies, or acquired in the course of the performance
1385 of official duties. The Commissioner of Social Services shall disclose (1)
1386 to any authorized representative of the Labor Commissioner such
1387 information directly related to unemployment compensation,
1388 administered pursuant to chapter 567 or information necessary for
1389 implementation of sections 17b-688b, 17b-688c and 17b-688h and
1390 section 122 of public act 97-2 of the June 18 special session, (2) to any
1391 authorized representative of the Commissioner of Mental Health and
1392 Addiction Services any information necessary for the implementation
1393 and operation of the basic needs supplement program, or the Medicaid
1394 program for low-income adults, [established] administered pursuant
1395 to section [17b-261n] 17b-261, as amended by this act, (3) to any
1396 authorized representative of the Commissioner of Administrative
1397 Services or the Commissioner of Emergency Services and Public
1398 Protection such information as the Commissioner of Social Services
1399 determines is directly related to and necessary for the Department of
1400 Administrative Services or the Department of Emergency Services and
1401 Public Protection for purposes of performing their functions of
1402 collecting social services recoveries and overpayments or amounts due
1403 as support in social services cases, investigating social services fraud or
1404 locating absent parents of public assistance recipients, (4) to any
1405 authorized representative of the Commissioner of Children and

1406 Families necessary information concerning a child or the immediate
1407 family of a child receiving services from the Department of Social
1408 Services, including safety net services, if the Commissioner of Children
1409 and Families or the Commissioner of Social Services has determined
1410 that imminent danger to such child's health, safety or welfare exists to
1411 target the services of the family services programs administered by the
1412 Department of Children and Families, (5) to a town official or other
1413 contractor or authorized representative of the Labor Commissioner
1414 such information concerning an applicant for or a recipient of
1415 assistance under state-administered general assistance deemed
1416 necessary by the Commissioner of Social Services and the Labor
1417 Commissioner to carry out their respective responsibilities to serve
1418 such persons under the programs administered by the Labor
1419 Department that are designed to serve applicants for or recipients of
1420 state-administered general assistance, (6) to any authorized
1421 representative of the Commissioner of Mental Health and Addiction
1422 Services for the purposes of the behavioral health managed care
1423 program established by section 17a-453, (7) to any authorized
1424 representative of the Commissioner of Public Health to carry out his or
1425 her respective responsibilities under programs that regulate child day
1426 care services or youth camps, (8) to a health insurance provider, in IV-
1427 D support cases, as defined in subdivision (13) of subsection (b) of
1428 section 46b-231, information concerning a child and the custodial
1429 parent of such child that is necessary to enroll such child in a health
1430 insurance plan available through such provider when the noncustodial
1431 parent of such child is under court order to provide health insurance
1432 coverage but is unable to provide such information, provided the
1433 Commissioner of Social Services determines, after providing prior
1434 notice of the disclosure to such custodial parent and an opportunity for
1435 such parent to object, that such disclosure is in the best interests of the
1436 child, (9) to any authorized representative of the Department of
1437 Correction, in IV-D support cases, as defined in subdivision (13) of
1438 subsection (b) of section 46b-231, information concerning noncustodial
1439 parents that is necessary to identify inmates or parolees with IV-D
1440 support cases who may benefit from Department of Correction

1441 educational, training, skill building, work or rehabilitation
 1442 programming that will significantly increase an inmate's or parolee's
 1443 ability to fulfill such inmate's support obligation, (10) to any
 1444 authorized representative of the Judicial Branch, in IV-D support cases,
 1445 as defined in subdivision (13) of subsection (b) of section 46b-231,
 1446 information concerning noncustodial parents that is necessary to: (A)
 1447 Identify noncustodial parents with IV-D support cases who may
 1448 benefit from educational, training, skill building, work or
 1449 rehabilitation programming that will significantly increase such
 1450 parent's ability to fulfill such parent's support obligation, (B) assist in
 1451 the administration of the Title IV-D child support program, or (C)
 1452 assist in the identification of cases involving family violence, or (11) to
 1453 any authorized representative of the State Treasurer, in IV-D support
 1454 cases, as defined in subdivision (13) of subsection (b) of section 46b-
 1455 231, information that is necessary to identify child support obligors
 1456 who owe overdue child support prior to the Treasurer's payment of
 1457 such obligors' claim for any property unclaimed or presumed
 1458 abandoned under part III of chapter 32. No such representative shall
 1459 disclose any information obtained pursuant to this section, except as
 1460 specified in this section. Any applicant for assistance provided through
 1461 said department shall be notified that, if and when such applicant
 1462 receives benefits, the department will be providing law enforcement
 1463 officials with the address of such applicant upon the request of any
 1464 such official pursuant to section 17b-16a.

1465 Sec. 40. Section 17b-260d of the general statutes is repealed. (*Effective*
 1466 *July 1, 2013*)

1467 Sec. 41. Sections 17b-261n, 17b-311, 17b-490, 17b-491, 17b-492 and
 1468 17b-493 to 17b-498, inclusive, of the general statutes are repealed.
 1469 (*Effective January 1, 2014*)

This act shall take effect as follows and shall amend the following sections:		
Section 1	July 1, 2013	10-295(b)

Sec. 2	<i>July 1, 2013</i>	17b-607
Sec. 3	<i>July 1, 2013</i>	17b-340(f)(4)
Sec. 4	<i>July 1, 2013</i>	17b-340(h)(1)
Sec. 5	<i>October 1, 2014</i>	New section
Sec. 6	<i>July 1, 2013</i>	17b-239
Sec. 7	<i>July 1, 2013</i>	17b-239e(b)
Sec. 8	<i>July 1, 2013</i>	17b-242(a)
Sec. 9	<i>July 1, 2013</i>	17b-261m(a)
Sec. 10	<i>July 1, 2013</i>	17b-239c(a)
Sec. 11	<i>July 1, 2013</i>	17b-28e
Sec. 12	<i>January 1, 2014</i>	17b-261
Sec. 13	<i>January 1, 2014</i>	17b-256f
Sec. 14	<i>January 1, 2014</i>	17b-551
Sec. 15	<i>January 1, 2014</i>	17b-552
Sec. 16	<i>from passage</i>	17b-278i(a)
Sec. 17	<i>from passage</i>	17b-340c(a)
Sec. 18	<i>July 1, 2013</i>	17a-22h
Sec. 19	<i>July 1, 2013</i>	17a-22p
Sec. 20	<i>January 1, 2014</i>	17b-10a
Sec. 21	<i>January 1, 2014</i>	38a-556a(b)
Sec. 22	<i>January 1, 2014</i>	29-1s(a)
Sec. 23	<i>January 1, 2014</i>	12-746(e)
Sec. 24	<i>January 1, 2014</i>	10a-132e(b)
Sec. 25	<i>January 1, 2014</i>	17a-22f(a)
Sec. 26	<i>January 1, 2014</i>	17a-22h(a)
Sec. 27	<i>January 1, 2014</i>	17b-28(a)
Sec. 28	<i>January 1, 2014</i>	17b-261m(a)
Sec. 29	<i>January 1, 2014</i>	17b-274
Sec. 30	<i>January 1, 2014</i>	17b-274a
Sec. 31	<i>January 1, 2014</i>	17b-274c(a)
Sec. 32	<i>January 1, 2014</i>	17b-274d(e)
Sec. 33	<i>January 1, 2014</i>	17b-274e
Sec. 34	<i>January 1, 2014</i>	17b-280(a)
Sec. 35	<i>January 1, 2014</i>	17b-429
Sec. 36	<i>January 1, 2014</i>	17b-491b
Sec. 37	<i>January 1, 2014</i>	20-619(c)
Sec. 38	<i>January 1, 2014</i>	17a-22j(b)(11)
Sec. 39	<i>January 1, 2014</i>	17b-90(b)
Sec. 40	<i>July 1, 2013</i>	Repealer section
Sec. 41	<i>January 1, 2014</i>	Repealer section

Statement of Legislative Commissioners:

In section 2(c), language was redrafted to conform with the style of the general statutes; in section 13, new language was redrafted for clarity and consistency with federal law; in section 28(a), the phrase "provided the Department of Social Services completes a fiscal analysis prior to implementation of the impact on each such provider of considering utilization as a factor" was deleted after the word "neutrality" for accuracy and consistency with section 9; and sections 38 and 39 were added to delete references to statutes being repealed in section 41.

<i>HS</i>	<i>Joint Favorable Subst. C/R</i>	APP
<i>APP</i>	<i>Joint Favorable Subst.</i>	